ADVANCED ORTHOPEDICS INSTITUTE

Alfred J. Cook, Jr., M.D.

Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Secondary Address: _____

_____

Date of Birth: _____ SSN: _____ Sex: _____ Marital Status: _____

Are you: Retired? ☐ Student? ☐ Work Full time? ☐ Work Part time? ☐ Unemployed? ☐

Employer: _____ Employer's Phone: _____

Spouse Name: _____ Spouse DOB: _____

Spouse's Employer: _____ Employer's Phone: _____

Parent Name (if minor): _____ Parent SSN: _____ Parent DOB: _____

Parent's Employer: _____ Employer's Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Primary Insurance: _____ Subscriber Name: _____

Insurance Address: _____

Policy #: _____ Group#: _____

Secondary Insurance: _____ Subscriber Name: _____

Insurance Address: _____

Policy #: _____ Group#: _____

Who is your Primary Care Physician? _____

Who referred you to us? _____

Which pharmacy and location do you prefer? _____

Do you have allergies? ☐ Yes ☐ No

If yes, please list them: _____

IT IS OUR POLICY THAT ALL OFFICE VISITS AND OFFICE SERVICES ARE TO BE PAID FOR AT THE TIME THESE SERVICES ARE RENDERED.

HOW WILL YOU BE PAYING? ☐ Check ☐ Cash ☐ Charge

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, WHETHER OR NOT THEY ARE PAID FOR OR SUPPLEMENTED BY INSURANCE COMPANY.

New Beneficiary Signature Regulations in effect since April 1, 1992, allow physicians {or other suppliers in most cases) to obtain from the beneficiary and retain in their files, a lifetime signature authorization for the physician or supplier to submit assigned or unassigned claims on the beneficiary's behalf.
The beneficiary must sign a brief statement substantially as follows: "I request that payment for authorized Medicare benefits and any other insurance benefits be made either to me or on my behalf to Advanced Orthopedics Institute for any services furnished me by Advanced Orthopedics Institute. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services."

_____ _____

Signature of Patient or Responsible Party Date

ADVANCED ORTHOPEDICS INSTITUTE

Please fill out this form in its entirety.

PATIENT INFORMATION

Patient: _____ Date: _____

Date of Birth:_____ Height: _____ Weight: _____

Current Problem: _____

What are you being seen for today? _____

Date of injury or start of pain: _____

Is this work related? ☐ Yes ☐ No

Is this the result of a motor vehicle accident: ☐ Yes ☐ No

Pain Description

Severity of your pain? ☐ Mild ☐ Moderate ☐ Severe

Type of pain? ☐ Sharp ☐ Dull ☐ Other: _____

Social History

Do you smoke cigarettes? ☐ Current ☐ Former ☐ Never

How long have you smoked? ☐ >1 year ☐ 1-10 years ☐ 10+ years

How many packs per day? ☐ <1 pack ☐ 1-2 packs ☐ 3+ packs

Do you drink alcohol? ☐ Yes ☐ No

How many drinks? ☐ 1-2 per day ☐ 1-2 per week ☐ 1-2 per month

Do you have any history of: ☐ Anxiety ☐ Depression ☐ Drug/alcohol abuse

Family History

Mother:	☐ Cancer	☐ Heart Disease	☐ Stroke	☐ Arthritis	☐ Diabetes	☐ Osteoporosis
Father:	☐ Cancer	☐ Heart Disease	☐ Stroke	☐ Arthritis	☐ Diabetes	☐ Osteoporosis
Grandparents:	☐ Cancer	☐ Heart Disease	☐ Stroke	☐ Arthritis	☐ Diabetes	☐ Osteoporosis

Allergies (Please list all allergies and your reaction)

_____ _____

_____ _____

_____ _____

Medications (Please list name of medications and dosage) or ☐ See attached List (If you have a premade list)

_____ _____

_____ _____

_____ _____

Surgeries (Please list surgery type and year)

_____ _____

_____ _____

_____ _____

_____ _____

Patient Signature Date

ADVANCED ORTHOPEDICS INSTITUTE

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name: _____ Birth Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize Advanced Orthopedics Institute of 1400 North US Highway 441, Suite 552, The Villages, FL 32159 to disclose my protected health information to the following people: (Family, Friends, etc.)

_____ _____

_____ _____

_____ _____

Name Relation to patient

Information to be released:

_____ All

_____ X-ray Reports/MRI

_____ Laboratory Reports

_____ Allergy Records

_____ Medicare History, Examination Reports

_____ Surgical Reports

_____ Hospital Records including Reports

_____ Prescriptions

_____ Drug Abuse

_____ Other: (Please specify) _____

*A listing of the statutory exceptions to release of HIV test results without consent is available.

Purpose for Need of Disclosure:

_____ At the request of the individual

_____

_____

I understand that the health information disclosed, as a result of this authorization, may no longer be protected by the federal privacy standards and my health information might be disclosed without obtaining my authorization.

I understand that I have the right to:

Receive a copy of this authorization.

Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.

Revoke this authorization except to the extent that the person(s) and or organizations(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s):

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative (authority to act on patient's behalf): Relation to patient _____

ADVANCED ORTHOPEDICS INSTITUTE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I, _____ acknowledge that I have read a copy of Advanced Orthopedics Institute Notice of Privacy Practices. This notice describes how Advanced Orthopedics Institute may use and disclose my protected health information, utilize certain restrictions on the use and disclosure of my healthcare information, and upholds rights I may have regarding my protected health information.

I wish to be contacted in the following manner: (check all that apply)

_____ Home Phone:_____

_____ O.K. to leave message with detailed information

_____ Leave message with call-back number only

_____ Work Phone:_____

_____ O.K. to leave message with detailed information

_____ Leave message with call-back number only

_____ Written Communication

_____ O.K. to mail to my home address

_____ O.K. to mail to my work/office address

_____ O.K. to fax to this number

_____ Other: _____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birth Date

.....

For office use only

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to whom Address or fax number	1	Description of disclosure/ Purpose of disclosure	By whom disclosed	2	3

1. Check this box if the disclosure is authorized.
2. Type key: T=Treatment records; P=Payment information; O=Healthcare operations
3. Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other